BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **WILLIAM H. CASTRO, M.D.** Holder of License No. **18402** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-05-0988A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 11, 2007. William H. Castro, M.D., ("Respondent") appeared before the Board with legal counsel Stephen W. Myers for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 18402 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0988A after receiving a complaint regarding Respondent's care and treatment of a thirty-one year-old female patient ("HC"). Respondent provided prenatal care to HC, a Gravida 5 Para 3, with a prior Cesarean Section ("C-Section"). Respondent ordered HC admitted for induction on September 25, 2000 at thirty-nine weeks gestation. Nursing staff began the induction at 9:00 p.m. using Prostaglandin gel. HC was admitted to labor and delivery at 11:00 p.m. HC's labor progressed. At 7:00 a.m. on September 26 a requested epidural was administered. HC's labor continued to progress and at 4:30 p.m. spontaneous rupture of membranes occurred while she was pushing. Nursing staff informed HC she was occiput posterior and another physician in practice with Respondent ("Dr. R") was called

to deliver the baby at 5:21 p.m. On delivery, nuchal cord was noted times one and Apgars were 6 and 8. The infant was transferred to neo-natal intensive care unit ("NICU") requiring two chest tubes for pneumothorax bilaterally. Although contacted by nursing staff during HC's delivery, Respondent did not see HC until the day following delivery and, according to the complaint, was unaware of the events surrounding the delivery or the location of the infant in the NICU.

4. In 2000 Respondent was in practice with five obstetrician/gynecologists who shared call. The physician on call covered his/her own patients as well as all the patients for the group. On a typical day Respondent was either in the operating room, the office, or doing deliveries. Respondent would see his patients in the hospital if he was informed there was an issue or on rounds, typically in the morning or afternoon. If there were any pending cases at the end of a shift they were transferred to the physician on call for that evening. Respondent was notified of HC's status the morning of the 26th and everything seemed well. Respondent was tied up that afternoon and turned HC's care over to Dr. R at approximately 4:00 or 4:30 p.m.

5. It is customary for obstetricians to send to the hospital a form containing the patient's entire history and physical when the patient is at thirty-six weeks. When the patient presents for delivery any notes made from thirty-six weeks until that point are faxed to the hospital. The hospital record for HC contains the record sent over by Respondent at thirty six weeks, but there is no update for the three week period between when the record was sent and HC presented for delivery and there is no history and physical for the date she presented.

6. The obstetrical indication for Respondent ordering HC's induction of labor was a history of macrosomia and, if she was going to attempt a vaginal birth after C-Section ("VBAC"), it was best to deliver the baby before it reached an unreasonable weight range. Respondent's custom if doing a VBAC is to induce at a time it would be more reasonable to have a baby at a certain size, rather than a larger size. In many cases Respondent does not see the patient until

she is ready to deliver, unless the nursing staff calls and tells him there is an issue that has to be addressed. Respondent was in the operating room at another hospital when HC delivered.

7. Respondent did not document that when he transferred care to Dr. R told him that HC was not a routine patient and there was an increased risk of uterine rupture. Respondent did not know if the nursing staff communicated to HC that he was unavailable because he was performing surgery at another hospital and that her care and been turned over to Dr. R. According to Respondent he did not know the status of HC's baby post-delivery because Dr. R did not communicate that to him. On the day HC delivered Respondent performed a surgery at another hospital in the morning, returned to his office and performed another surgery in the evening. Respondent did not at any point during the day go into the hospital to check on HC's status. Respondent was in communication with the nursing staff who reported HC was in stable condition and progressing slowly. Respondent believed there was nothing else he could contribute by going in to see her. HC was in labor for twenty hours during which time Respondent did not document her status or perform an evaluation or communicate with her.

8. The American College Of Obstetrics and Gynecology ("ACOG") Guidelines for 1999 regarding a patient who has had a previous C-Section and has begun labor after administration of Prostaglandin Gel say that "the patient should be evaluated promptly." Respondent argued the evaluations were done by nursing staff.

9. The standard of care requires Respondent to personally evaluate a patient and her fetus for fetal distress when a patient who has had a previous Caesarean section is admitted for induction.

10. Respondent deviated from the standard of care when he did not personally evaluate HC or her fetus during the approximately twenty hours she was in the hospital.

11. HC's uterus could have ruptured.

12. It is mitigating that Respondent was in contact with the nursing staff by telephone and that the pneumothorax suffered by HC's infant was not the result of the quality of care during labor and delivery.

13. It is aggravating that Respondent arranged for HC's labor to be induced and then did not personally evaluate her.

14. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent did not ensure HC's records for the three weeks prior to her delivery were transmitted to the hospital, thereby failing to provide sufficient information for subsequent treating practitioners.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to personally evaluate prior to delivery a VBAC patient induced with prostaglandin gel and for inadequate medical records.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 8th day of June 2007.

ARIZONA MEDICAL BOARD
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STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 8th day of June, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
8th day of June, 2007, to:

Stephen Myers
Myers & Jenkins, PC
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Phoenix, Arizona 85012-2910

William H. Castro, M.D.
Address of Record